**COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH**
**Office of the Medical Director**
**Indigent Medications Program (IMP)**
**Coordinator-Suzane Wilbur**
**213-509-3967**
**213-738-2060**

# RISPERIDONE/RISPERDAL

**Client Eligibility Criteria**:
Must live in US.  Citizenship not required.
Does not have benefits, e.g., SSI, Medi-Cal, HMO, etc.
May receive General Relief or Interim Funding.
Has no prescription coverage.  Medicare ok.
**Janssen Process**:
First application good for 4 months.  (Reminders will be sent after 3 months.)
Second application good for 8 months. (Reminders will be sent after 7 months.)
Notify Janssen if client receives benefits or financial situation changes.
**Checklist:**
___PAP identifier "Y" is entered into client's IS Financial Screen in HMO/PHP field **before
   entering the PATS prescription** that corresponds to this application.

___MD has completed and signed Risperidone PAP application Form.  Please request a **four months'
   supply of medication from the PAP.  (Request an 8 month supply on the second app.)**

___Risperidone prescription **for one months' supply of medication** is entered into PATS.
   **Make sure the PAP identifier is in the IS prior to entering this prescription.**

___DMH form Authorization for Use or Disclosure of Protected Health Information (PHI) is
   explained and client has signed. This form is filed in client's chart; do not send to DMH
   Pharmacy Services.

___Risperdal PAP application form is explained and client has signed.

___Risperdal Authorization to Share Health Information for Reimbursement or Patient Assistance
   Programs form is explained and client has signed.

**Procedure:**
___Risperdal PAP application forms, including Authorization to Share Health Information for
    Reimbursement or Patient Assistance Programs form and copy of DMH PFI, is faxed to
    Janssen, **888-526-5170**.

___Risperdal PAP application form (form only) is faxed to DMH Pharmacy Services, **213-637-2550.**
   **(Please write MIS# on this copy.)**

___Risperdal PAP original application forms are filed in central location in clinic.

___Date is entered into appropriate section of DMH form Account Tracking Sheet.